OTTAWA

Lower drug prices and greater industrial benefits can coexist, says CDMA

The 1969 amendments to the Patent Act have given rise to a "promising pharmaceutical industry" which is already meeting the principal social benefit objective of lower drug costs. That was the message the Canadian Drug Manufacturers Association (CDMA) presented to the Eastman Commission recently in Ottawa.

Indeed, the recurring theme in the 124-page report is how to encourage a strong pharmaceutical industry in Canada while keeping drug costs to consumers low. The solution? A "made in Canada" policy that stimulates the developing generic sector and rewards the multinational companies only for those processes invented in Canada to produce products fully manufactured in Canada, says the CDMA.

"The CDMA members believe that the evidence clearly shows that any deficiency in the amount of research and development conducted in Canada is not a result of compulsory licensing", says the report. "In fact, there is reason to believe that research and development has increased and will increase in Canada through the generic sector. Notwithstanding the foregoing, CDMA members would not be opposed to very specific and limited exceptions to compulsory licensing if it could be shown that such exceptions were guaranteed to produce substantial benefits to Canada and would not result in higher drug prices."

Such specific exemptions from compulsory licensing would stimulate investment in all phases of research in Canada, says the report. "It would be a clear statement to the science community that we value this sector."

The CDMA also proposed special government programs for industrial growth using the taxation system, specific grants and other incentives. "The programs", says the CDMA, "must be designed within the international framework to permit both Canadian and nonCanadian owned firms to qualify. The cost of industrial growth would be spread across the tax system instead of being borne by only those who require medication, or by those provincial agencies responsible for drug costs within provincial programs." Among its other proposals, the CDMA is calling for greater funding for pharmaceutical research through the Medical Research Council, a program to foster greater use of generic products, an improvement of the regulatory process for drug clearance and better education of physicians through the Canadian Medical Association about the benefits of prescribing generic products.

The Canadian Drug Manufacturers Association recommends that:

- Existing compulsory licensing legislation remain in force to provide for competition which has effectively moderated drug prices.
- Limited exemptions from compulsory licenses be given for up to 5 years for pharmaceutical processes invented in Canada provided that products utilizing such processes are fully manufactured in Canada.
- Biotechnological innovations receive full patent protection except for those innovations which involve medicines.
- Government provide increased incentives for basic pharmaceutical research through the Medical Research Council of Canada, and industrial incentives through the Department of Regional and Industrial Expansion.

SASKATCHEWAN

Saskatchewan to respond to "blackmail" of Canada Health Act

Another province has responded to the "blackmail" of the Canada Health Act. It's Saskatchewan, the province that introduced Medicare to Canada and where, two decades ago, physicians went on strike for 23 days to win the right to opt out of the government's plan and directly bill patients for amounts up to or beyond the amount they would be reimbursed by Medicare.

Saskatchewan physicians set a precedent as Medicare in all provinces eventually guaranteed doctors that right. Now, Saskatchewan Health Minister Graham Taylor wants to change the situation in the Prairie province. He recently told the Saskatchewan Medical Association that provincial cabinet intends to end extra billing by doctors in the province. He did not say how, except that he wanted to accomplish it "in a spirit of cooperation that is not going to result in the loss or reduction of service".

Extra billing in Saskatchewan amounts to $153 000 a month or only 2% of all claims handled by the Medical Care Insurance Commission. Based on those figures, Saskatchewan would lose more than $1.8 million annually in federal funding for health care. Dr. Ernie Baergen, executive director of the 1400 member SMA, said he could not say how the physicians will respond to Mr. Taylor's idea until the association's annual meeting in

November in Regina. However, he did say that according to the SMA's representative assembly, mode 3 billing — defined as selective direct patient billing — is not even negotiable.

Extra billing has been banned in British Columbia and Nova Scotia already and has been discussed in Manitoba. Dr. Baergen says he is not surprised the provinces are considering the ban. "It is in response to the blackmail of the Canada Health Act", he said.

NOVA SCOTIA

Recommendations of select committee on health revealed

On Apr. 15, 1982 a select committee on health was established by the government of Nova Scotia to gather information about the health care system in the province. The committee heard from 114 organizations and individuals and received 131 submissions during the 2-year period.

A two-volume report has been produced and the first volume is due to be released shortly. However, Vince MacLean, Liberal MLA and opposition health critic, has released a list of the recommendations contained in that first volume. They include:

Health care financing

- That the federal government be encouraged to provide adequate increased funding to Nova Scotia to help cover the costs of additional required health services.
- That the federal government be encouraged to cooperate in providing appropriate funding mechanisms for services to be provided through a comprehensive coordinated home care program in Nova Scotia.

Prevention

- That the health care programs and services of a preventative and health promotion nature be given a higher priority by the government of Nova Scotia.
- That a committee be established under the chairmanship of an official of the Department of Health to devise a preventative medicine strategy for the province of Nova Scotia. The committee should follow the approach utilized by the federal/provincial/territorial ad hoc committee on national health.
- That sufficient resources be provided to review and evaluate, at regular intervals, the effectiveness of the programs comprising the preventative medicine strategy developed for Nova Scotia. This procedure should provide some indication of the effectiveness of the programs and provide the flexibility to modify and/or change programs as required.
- That the citizens of Nova Scotia be provided with a no smoking area in specific public places, giving major emphasis to the work site, transit systems, hospitals, child care centers, educational institutions and all government accommodations.
- That the government of Nova Scotia discourage use of tobacco.
- That the voluntary organizations which have proven to be effective in developing and implementing significant smoking cessation programs be encouraged and supported.
- That blood testing for impairment be made mandatory in the case of an accident.
- That the Nova Scotia government lower the permissible levels of alcohol and drugs in the blood system when operating a motor vehicle.
- That a daily physical fitness program be offered in the schools from grades one through twelve to provide children with a foundation upon which to build a healthy lifestyle.
- That the Department of Education provide a comprehensive health education (sequential life sciences study program) from grades one through twelve.
- That the prenatal education services available to the public be improved and that the health care workers be encouraged to carry out health promotion counselling in the area of smoking, nutrition and drug use.
- That the province of Nova Scotia reproductive care program be expanded throughout the program so that prenatal counselling includes lifestyle risk assessment and appropriate follow-up.
- That prenatal nutrition counselling services be covered as an insured service under M.S.I.

Hospitals

- That government pursue a target of five acute hospital beds per 1000 population in conjunction with the introduction of more extensive services, such as a coordinated home care program outside of hospitals.
- That extended care (type 111) beds be established in Nova Scotia with an individual overall target of 1:1000 population.
- That in areas with a higher than average supply of beds taking into account the levels of service offered (community/regional/tertiary) that no new acute beds be added.
- That the government provide incentives, such as 100% renovation grants, to encourage necessary changeovers from acute care beds to extended care beds or to ambulatory care services.
- That the provincial Hospital Insurance Act be amended to allow hospitals to deliver a broader range of services operating through but not necessarily in the institutions.
- That hospitals which provide services efficiently should be allowed to retain unspent portions of their budgets, to encourage flexibility and innovation.
- That short-term rehabilitation services be developed in Nova Scotia, and that appropriate numbers of psychiatrists, physiotherapists and occupational therapists be employed to provide this service.

Home care

- That the government of Nova Scotia fully implement a comprehensive, coordinated home care program for the residents of Nova Scotia.
- That the home care program include a core of services including homemakers, nursing, occupational therapy, physiotherapy and the active participation of physicians, within the multidisciplinary team, to ensure regular case conferencing so that relevant information about the patient is always available for home care patients.
- That the government of Nova Scotia establish an advisory committee that is representative of a cross section of appropriate health and social service professionals, to advise the government on the planning of a coordinated home care program.

Medicare and hospital insurance

- That progressive taxation instruments be used, instead of health care premiums, if additional provincial revenues are required to finance health care in Nova Scotia.

UNITED STATES

Florida court defeats amendment to cap malpractice awards

In what was clearly seen as a political shootout, Florida's lawyers outdrew Florida's doctors by preventing a medical malpractice restraint amendment from being put on the Nov. 6 election ballot.

Amendment 9, crafted by the Florida Medical Association (FMA), would have capped pain and suffering awards in professional liability cases at $100 000, would have allowed judges to dismiss summarily suits they felt groundless and would have limited doctors' (or other professionals') liability to their share of the responsibility for injuries.

The FMA argued that the amendment, if enacted, would save $13 billion by 1990 in medical malpractice premiums and associated health costs generated by practising defensive medicine. According to the FMA, many physicians had already signed pledges stating that they would pass along to their patients the savings derived from reduced malpractice insurance premiums.

The Academy of Florida Trial Lawyers said the amendment would deprive injured persons of rightful compensation. Many lawyers interviewed in the media also admitted it would significantly lower their legal fees since, in Florida as in other states, many such cases are taken by lawyers on a contingency basis.

The Academy of Florida Trial Lawyers challenged the amendment in the Florida supreme court on grounds that it was poorly crafted and constitutionally ambiguous, that it was overly broad and that the summary of its intent (to lower medical costs) was misleading. Florida law demands that such amendments be limited to one subject. In a unanimous verdict, Florida's supreme court upheld the lawyers' challenge and struck the amendment from the ballot in a one paragraph order. It pledged to deliver a full explanation of its action at a later date.

Florida's physicians, who had raised more than $3.5 million, first, to get enough signatures to have the amendment added to the ballot and then to promote it aggressively on prime time television and in print advertising, were clearly devastated by the court's ruling. The state's lawyers had, according to widespread media reports, raised $1.5 million for their own television campaign against the amendment.

The FMA hired out-of-state citizen's initiative organizers to get the required number of signatures (280 000 eligible voters) to have the amendment placed on the ballot. The FMA signed up more than 600 000 people on the claim that the amendment was a health care cost containment device. More than 10 000 Florida doctors had each pledged $300 to promote the amendment.

In reaction to their defeat in court, some physicians were pledging to use the weight of their 600 000 signatures to carry on the battle in the state legislature. But the legislature has in the past been clearly unsympathetic to any action that would limit malpractice awards.

American MDs use more diagnostic tests than British MDs, study shows

A recently published British–American study has shown American physicians to be far more liberal users of diagnostic technology than their British counterparts.

The study, from Brigham and Women's Hospital and Harvard University in Massachusetts, and St. Thomas Hospital and St. Mary's Hospital medical schools in London,

← For prescribing information see page 1287

has in fact shown that Americans use up to 40 times more outpatient tests than do British physicians in treating common conditons such as uncomplicated hypertension.

The comparison, published in the Oct. 5 issue of *JAMA*, involved retrospective data collected from 351 American patients treated by 30 community based internists in Massachusetts, and 511 British patients treated by 18 general practitioners in greater London. All patients were being treated for uncomplicated hypertension.

The results showed American physicians in the test group used electrocardiograms 41 times more often than did their British counterparts. Americans also used more often plain roentgenograms (other than chest), cervical cytological tests, blood cell counts, urinalyses, urine chemistry tests, upper gastrointestinal series and intravenous pyelograms and bacteriological tests from two to eight times more often than British doctors.

"Why American internists ordered so many more tests is both puzzling and intriguing", said the report's authors. They attributed these differences to several variables, among them "a pervasive American fascination with technical advances, machinery, engineered solutions, and procedures".

But this fascination, said the authors, was equally compelling among patients as among their doctors. "In the United States, common laboratory tests themselves have been shown to please patients, reassure them, and in certain instances even improve their functioning, regardless of the results."

Another factor contributing to the preoccupation with tests, said the authors, was the easy access American physicians have to this technology. The study revealed that all of the American physicians surveyed had electrocardiographs in their offices, 20 of 30 had equipment for performing urinalyses, 11 had machinery for performing blood cell counts and seven had equipment for chest roentgenograms, upper gastrointestinal series and barium enema examinations.

In the next *CMAJ*

The doctor as patient

During the summer of 1983 Dr. Denise Bowes spent 12 weeks in hospital with an illness diagnosed as Guillain–Barré syndrome. At the height of the illness she was almost completely paralysed but remained mentally alert. Dr. Bowes describes the shortcomings of the care she received and makes recommendations for the care of critically ill conscious patients. In an accompanying editorial Dr. Peter Morgan suggests ways in which hospital routines can be modified to improve patients' physical comfort and mental security.

Breast self-examination

There are conflicting results as to whether breast self-examination (BSE) leads to earlier diagnosis of breast cancer, but few investigators have considered what is actually done during BSE. Dr. T. Gregory Hislop and colleagues, from the Cancer Control Agency of British Columbia, undertook a study of the prediagnostic levels of BSE and routine medical examination in 416 women with breast cancer in an effort to determine the relation between screening practices, tumour detection and the extent of disease at the time of diagnosis.

The Australian doctors' dispute

Public hospitals in New South Wales are rapidly emptying of doctors after sudden deterioration of a continuing dispute between doctors and the government regarding the profession's rights and privileges in the new Medicare plan. Medical writer Ron Lord reports from Sydney.

Organ transplantation in Canada

Canada needs an independent federally funded organ and tissue procurement agency. At least that was one of the recommendations made during a multi-disciplinary transplant workshop organized by the Department of National Health and Welfare. News and Features Editor Brian Bérubé looks at the range of issues confronting the medical profession and the public in matching available organs with needy recipients and the difficult moral, ethical and legal implications.